end-systolic volume (p=0.004) and decrease in LVEF (57 [54; 63] vs 64 [61; 69]%, p=0.003) in comparison with Group 1.

It's interesting that patients of both groups didn't have differences in values of diameter of the right ventricle (27.3 [25; 30] mm 26.4 [24; 28] vs p>0.05), but pulmonary artery systolic pressure was higher in patients of Group 2 (40.7 [37; 42] mmHg vs 32.3 [28; 35] mmHg, p<0.001).

Conclusion. Patients with persistent form of AF were predominantly male and had significantly higher body mass index. According to the results of echocardiography, patients with persistent form of AF had larger sizes of atria and volumes of LV as well as lower LVEF, which is associated with the formation of LV systolic dysfunction. A possible connection between the obtained results and future adverse outcomes of AF progression requires further studies.

EVALUATING TREATMENT APPROACHES IN MIRIZZI SYNDROME

Gardhi Arachchige Reshmi Dileka

Grodno State Medical University, Grodno, Belarus

Introduction. Mirizzi syndrome is a rare but serious complication of gallstone disease, which causes the compression of the common hepatic duct, potentially leads to strictures or Cholecystobilliary fistulas. The results show that incidence of MS has increased due to rising prevalence of gallstone disease and also due to delay in surgical intervention. It occurs in 1-5% of patients post cholecystectomy, with having a mortality rate of 11-14%. Preoperative diagnosis is often missed in this case but with only 12-22% correctly identified.

Aim of the study. Analysis of the results of treatment of patients with Mirizzi Syndrome.

Materials and methods. We present our clinical observation. The patient, a 66-year-old woman, was admitted to the surgical department of GRCH with a diagnosis of "Gallstone disease: chronic calculous cholecystitis, choledocholithiasis" for further examination and surgical treatment. She complained of periodic dull pain in the right hypochondrium, nausea, and bitterness in the mouth. From her medical history, she had been suffering from gallstone disease for a long time. A week prior to admission, she developed jaundice and was treated in a surgical hospital at her place of residence. Ultrasound examination revealed The gallbladder: wrinkled, with a 15 mm calculus in its projection; intrahepatic ducts are not dilated.", magnetic resonance imaging MRI was performed. The liver appeared normal in shape and size, without focal pathology. Intrahepatic bile ducts were not dilated, and the gallbladder was reduced in size and sclerosed, containing an irregularly shaped calculus measuring up to 15.5 x 11 mm. This calculus was prolapsing into the

common bile duct above the junction with the cystic duct. The common bile duct was not dilated, measuring 3.3 mm in diameter, with no visible additional formations in its lumen. The pancreas was normally positioned, with well-defined irregular contours and no focal pathology: head measuring 23 mm; body 18 mm; tail 16.7 mm. The Pancreatic duct was not dilated, and the peripancreatic tissue was normal.

Results and discussion. A decision was made to initiate surgical intervention with laparoscopy to clarify the diagnosis. During the operation, it was found that the gallbladder was fibrotically altered, measuring 7x3x2.5 cm, and was firmly adhered at the fundus to the duodenum. A 1.5 cm diameter calculus was palpated at the neck of the gallbladder. Additionally, intimate adherence of the neck of the gallbladder to the right semi circumference of the common hepatic duct was noted. The intraoperative diagnosis was "Cholelithiasis: chronic calculous cholecystitis. Sclerotic (Wrinkled) gallbladder. Mirizzi syndrome type I."

After laparotomy, the gallbladder was separated from its firm adhesion to the duodenum. A stone was found in the neck of the gallbladder, with a developing ulcer between Hartmann's pouch and the common hepatic duct. Upon separating the neck of the gallbladder from the hepatic duct, an ulcer defect of more than 2/3 of the circumference of the hepatic duct was observed, with a 1.5 x 1 cm calculus prolapsing into it. The diameter of the common hepatic duct and the common bile duct located below the ulcer was 0.5 cm. The right and left lobar ducts were cannulated with Dollinger probes and found to be patent, without calculi. Given the established condition, a hepaticojejunostomy was done on a Roux-en-Y loop using separate sutures of a monofilament, long-absorbing suture material (5.0), using microsurgical instruments. The presence of Mirizzi syndrome in this case was inferred from the results of ultrasound and MRI and was confirmed during laparoscopy. This clinical case illustrates the potential for non-invasive preoperative diagnosis of Mirizzi syndrome. If necessary, additional techniques such as magnetic resonance cholangiography, retrograde cholangiopancreatography, intraoperative cholangiography, and cholangioscopy may be used.

Conclusion. 1. Visualization of the "wrinkled gallbladder" with an enlarged proximal part of the d. hepaticocholedohus allows one to suspect Mirizzi syndrome when performing an ultrasound, magnetic resonance imaging helps to clarify the diagnosis before surgery. If necessary, perform magnetic resonance cholangiopancreatography, retrograde cholangiopancreatography, cholangioscopy, intraoperative cholangiography. 2. Roux-en-Y hepaticojejunostomy is one of the acceptable operations that allow to achieve a favorable result in the surgical treatment of Mirizzi syndrome. 3. Timely diagnosis of Mirizzi syndrome can prevent intraoperative iatrogenic lesions of the bile ducts.